EXHIBIT A

Texas Department of Insurance
Insurance License Renewal

Appointments

SOPHIA AHMED

Company	Active
AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS	08/28/2021
AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY	09/02/2021
INDEPENDENT ORDER OF FORESTERS, THE	08/02/2021

Have a payment or insurance license question? Call the Texas Department of Insurance at 512-676-6500. You also might be able to get your answer on the Texas Department of Insurance's website.

Need help with this portal? Call 1-877-452-9060 or email Support@TexasGovHelpDesk.com.

EXHIBIT B

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
EL PASO DIVISION

BRANDON CALLIER,	§	
	§	
Plaintiff,	§	
	§	
v.	§	**Case # 3:22-CV-00018-FM**
	§	
AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS a Florida Corporation, and **SOPHIA AHMED**	§	
	§	
Defendants.	§	

DECLARATION OF JAMES E. SHELTON

I, James E. Shelton, declare under penalty of perjury, declare as follows:

1. My name is James E. Shelton. I am over 21 years of age, and I am competent to give testimony. I make the statements in this declaration based on my own personal knowledge,
2. My personal cell phone number has a 484 area code.
3. On April 15, 2022, I received a phone call to my personal cell phone displaying 484-614-6381 on the caller ID.
4. I answered the phone call referenced in paragraph 3 and heard an automated voice message that began "Hi, this is Kate from senior benefits."
5. I pressed "one" and was connected to a telemarketer who solicited me for a life insurance policy.
6. The phone call disconnected before I was able to complete the purchase.
7. I declare under penalty of perjury that the foregoing is true and correct.

FURTHER SAYETH NAUGHT.

DECLARATION

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 19th day of April, 2022.

James E. Shelton

JAMES E. SHELTON

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
EL PASO DIVISION

BRANDON CALLIER,	§	
	§	
Plaintiff,	§	
	§	
v.	§	**Case # 3:22-CV-00018-FM**
	§	
AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS a Florida Corporation, and **SOPHIA AHMED**	§	
	§	
Defendants.	§	

DECLARATION OF DAVID SALAIZ

I, David Salaiz, declare under penalty of perjury, declare as follows:

1. My name is David Salaiz. I am over 21 years of age, and I am competent to give testimony. I make the statements in this declaration based on my own personal knowledge,
2. On March 11, 2022, I received a phone call to my personal cell phone displaying 325-255-8380 on the caller ID.
3. I answered the phone call referenced in paragraph 2 and heard an automated voice message that began "Hi, this is Kate from senior benefits."
4. I pressed "one" and was connected to a telemarketer who solicited me for a life insurance policy.
5. I purchased the life insurance policy while on the call referenced in paragraph 2. When the insurance policy arrived in the mail it was a life insurance policy issued by Pioneer

American Insurance Company which is part of the American Amicable Group of Insurance Companies.

6. Charles Turner was the agent of record on the insurance policy I purchased from Pioneer American Insurance Company.

7. I declare under penalty of perjury that the foregoing is true and correct.

FURTHER SAYETH NAUGHT.

DECLARATION

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 18TH day of April, 2022.

DAVID SALAIZ

FINAL EXPENSE

American Legacy

PIONEER AMERICAN INSURANCE COMPANY
P.O. BOX 240, WACO, TX 76703-0240 • (254) 297-2776

C807452

INDIVIDUAL LIFE INSURANCE APPLICATION (Please print in black ink)

Apptical 3026962

Proposed Insured DAVID (First) (Middle) SALAIZ (Last)

Address (No. & Street) 319 Valley Fairway

City El Paso State TX Zip Code 79907

Telephone interview completed [X] Yes [ ] No

(915) 929-1527 (Phone) _____ (Best time to call) [ ] am [ ] pm

E-mail Address salaiztransportation@gmail.com

[X] Male [ ] Female	Date of Birth	Age	State of Birth	Social Security Number	Height	Weight
	10/14/1955	66	TX	467-04-9146	5'7	180 lbs

Owner: Name _____ Relationship _____ SS# _____

Address

Primary Beneficiary	Relationship	Contingent Beneficiary	Relationship
Rose Salaiz	Spouse		

Plan: _____ **Face Amount of Insurance $** $12,000

[X] Immediate Death Benefit
[ ] Graded Death Benefit (Percentage of Face Amount)
[ ] Return of Premium Death Benefit

[ ] Check here if you are willing to accept any plan for which you qualify based on this application. The insurance for which you qualify may have a graded or return of premium death benefit for the first two (2) or three (3) years, a face amount less than any indicated on this application, and riders may not be available.

During the past 12 months have you used tobacco in any form (excluding occasional pipe and cigar use)? [ ] Yes [X] No

Rider: [ ] Grandchild/Great Grandchild Coverage ____ Number of Children Applying ____ Units [ ] Other _____
[ ] Child Rider ____ Units [X] ADB* Amt $ 12000 (*not available on Return of Premium Death Benefit)

Automatic Premium Loan Elected? [X] Yes [ ] No

Mode: [X] Bank Draft [ ] Draft 1st Prem on Req. Date [ ] Other Bank M Modal Prem $ $85.27

CWA: [ ] E-Check Immediate 1st Prem [ ] Collected $ 0.00

Mail Policy To: [ ] Agent [ ] Insured [X] Owner

Requested Policy Date: 03/25/2022

A. Do you have existing life insurance or an annuity contract? [ ] Yes [X] No
B. Will you replace an existing life insurance policy or an annuity? [ ] Yes [X] No

Company
Policy # Amount of Coverage $

Physician Name: Fransisco Guerra El Paso Tx City/State: Phone: (915) 594-4000

HEALTH INFORMATION

1. Are you currently hospitalized, confined to a nursing facility, a bed, or a wheelchair due to chronic illness or disease, currently using oxygen equipment to assist in breathing, receiving Hospice Care or home health care, or had an amputation caused by disease, or do you currently have any form of cancer (excluding basal cell skin cancer) diagnosed or treated by a medical professional, or do you require assistance (from anyone) with activities of daily living such as bathing, dressing, eating or toileting? ..... [ ] Yes [X] No
2. Have you had or been medically advised to have an organ transplant or kidney dialysis, or have you been medically diagnosed as having congestive heart failure (CHF), Alzheimer's, dementia, mental incapacity, Lou Gehrig's disease (ALS), liver failure, respiratory failure, or been diagnosed by a medical professional as having a terminal medical condition or end-stage disease that is expected to result in death in the next 12 months? ..... [ ] Yes [X] No
3. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)? ..... [ ] Yes [X] No

If any answer to questions 1 through 3 is answered "Yes" the Proposed Insured is not eligible for any coverage.

4. Have you ever been medically diagnosed or treated for complications of diabetes, including insulin shock, diabetic coma, retinopathy (eye), nephropathy (kidney), neuropathy (nerve damage/pain), or used insulin prior to age 50? ..... [ ] Yes [X] No
5. Have you ever been medically diagnosed, treated or taken medication for renal insufficiency, kidney failure, chronic kidney disease, or more than one occurrence of cancer in your lifetime (excluding basal cell skin cancer)? ..... [ ] Yes [X] No
6. Within the past 2 years have you had any diagnostic testing (excluding tests related to Human Immunodeficiency Virus (HIV)), surgery, or hospitalization advised by a medical professional which has not been completed or for which the results have not been received? ..... [ ] Yes [X] No
7. Within the past 2 years have you:
   a. been medically diagnosed or treated for angina (chest pain), stroke or TIA, cardiomyopathy, systemic lupus (SLE), cirrhosis, Hepatitis C, chronic hepatitis, chronic pancreatitis, chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, or required oxygen equipment to assist in breathing? ..... [ ] Yes [X] No
   b. had a heart attack or aneurysm, or had or been medically advised to have any type of heart, brain or circulatory surgery (including, but not limited to a pacemaker insertion, defibrillator placement), or any procedure to improve circulation? ..... [ ] Yes [X] No
   c. been medically diagnosed, or treated, or taken medication for any form of cancer (excluding basal cell skin cancer)? ..... [ ] Yes [X] No
   d. used illegal drugs, abused alcohol or drugs, had or been recommended by a medical professional to have treatment or counseling for alcohol or drug use or been advised to discontinue use of alcohol or drugs? ..... [ ] Yes [X] No

If any answer to questions 4 through 7 is answered "Yes" the Proposed Insured should apply for the Return of Premium Death Benefit Plan.

8. Within the past 3 years have you been medically diagnosed or treated, or hospitalized for:
   a. stroke, angina (chest pain), heart attack, aneurysm, heart or circulatory surgery or any procedure to improve circulation? ... [ ] Yes [X] No
   b. or taken medication for any form of cancer (excluding basal cell skin cancer), emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), ulcerative colitis, cirrhosis, Hepatitis C, or liver disease? ..... [ ] Yes [X] No
   c. paralysis of two or more extremities or cerebral palsy, multiple sclerosis, seizures, Parkinson's disease or muscular dystrophy? [ ] Yes [X] No

If any answer to question 8 is answered "Yes" the Proposed Insured should apply for the Graded Death Benefit Plan.

If all questions 1 through 8 are answered "No" the Proposed Insured should apply for the Immediate Death Benefit Plan.

Benefit Description		Annual Premium
Basic Policy - Immediate Death Benefit Whole Life Insurance to Age 110	$	920.88
Supp Ben - $12,000 Accidental Death Benefit	$	48.00 to Age 100
Total Annual Premium	$	968.88
Issued Method of Payment--------ABC Monthly	$	85.27
Other Methods of Payment Annual	$	968.88
Semiannual	$	502.85
Quarterly	$	253.85
Monthly	$	85.27

Premium Class:Non-Tobacco

Policy Fee (included in Total Annual Premium above)

Annual Policy Fee:	$90.00
Semi-Annual Policy Fee:	$46.71
Quarterly Policy Fee:	$23.58
Monthly Policy Fee:	$ 7.92

Insured: David Salaiz

Age: 66

Sex: Male

Policy Number: 0094771620

Face Amount: $12,000

Effective Date: March 25, 2022

Maturity Date: March 25, 2066

Texas Insurance Department Telephone Number (512) 463-6169

EXHIBIT E

C807452

CHILD, GRANDCHILD, AND GREAT GRANDCHILD COVERAGE - Children Proposed for Insurance (list additional children on a separate sheet):

Proposed Insured Name	Sex	Birthdate	Relationship	Proposed Insured Name	Sex	Birthdate	Relationship

PROPOSED CHILDREN'S HEALTH STATEMENT—To the best of my knowledge and belief, none of the children listed above for coverage have been treated for or told by a physician that they have or had any of the following medical conditions: Hypertension, heart or circulatory disorder, malignancy in any form, diabetes, sickle cell anemia, seizures, Down Syndrome, cystic fibrosis, cerebral palsy, hydrocephalus, paralysis, or hospitalized for asthma or any respiratory disorder in past 12 months. List the names of children that are exceptions to PROPOSED CHILDREN'S HEALTH STATEMENT.

Children listed as an exception are excluded from the appropriate Child Rider Coverage. Exceptions are:_____

AGREEMENT—I agree with Pioneer American Insurance Company (the Company) as follows: (1) To the best of my knowledge and belief, all answers and statements contained in this application are true, complete and correctly recorded. I will notify the Company of any changes in the statements or answers given in this application between the time of application and delivery of the policy; and (2) This application and any policy issued on the basis of such application shall form the entire contract; and (3) No change in this contract shall be effected without my written consent with regard to: (a) the amount of insurance; (b) age at issue; (c) classification of risk; (d) plan of insurance; or (e) benefits. If this application is declined by the Company, I will accept the return of any premium paid. Any person who knowingly presents a false statement in application for insurance may be guilty of a criminal offense and subject to penalties under state law.

AUTHORIZATION—In order to properly classify my application for life insurance, I authorize any and all physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; insurance companies and their business associates and those persons or entities providing services to the insurer's business associates which are related in any way to their insurance plans; the MIB, Inc. or other organization that has knowledge or records of me and my health to give such information to: (a) Pioneer American Insurance Company; and (b) its reinsurers. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself. I may revoke the authorization by sending a written revocation to the Company address of 425 Austin Ave., Waco TX 76701. I understand that if I refuse to sign this authorization to release my complete medical records, my application for insurance with the Company will be rejected.

All said sources, except the MIB, Inc., are authorized to give records or knowledge such as statements regarding hobbies, employment, criminal records or medical history that might be required to determine eligibility for insurance to any agency employed by the Company to collect and transmit data. I authorize Pioneer American Insurance Company to disclose any personal data gathered while processing this application. This data may be released to the following: (a) reinsuring companies; (b) the MIB, Inc.; (c) other persons or groups performing services in connection with this application; or (d) any others to whom it may be lawfully required or authorized. This authorization shall remain valid for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. A copy of this authorization shall be as valid as the original.

I acknowledge receiving the Fair Credit Reporting Act Notice, the MIB, Inc. Pre-Notice, the Terminal Illness Accelerated Benefit Rider and Confined Care Accelerated Benefit Rider Disclosure Forms, if applicable.

Signed at El Paso (CITY) TX (STATE) — Date of Application 3/14/2022 11:25:33 AM (MONTH DAY YEAR)

DAVID SALAIZ (Voice Signature on File) — SIGNATURE OF PROPOSED INSURED

DAVID SALAIZ (Voice Signature on File) — SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED)

AGENT'S REPORT

Does the proposed insured have any existing life insurance or annuity contract? ☐ Yes ☒ No

Is the proposed insurance intended to replace or change any existing life insurance or annuity? ☐ Yes ☒ No

I certify that I have personally asked each question on this application to the proposed insured(s), I have truly and completely recorded on the application the information supplied by him/her, and I witnessed their signature.

I certify that the Terminal Illness Accelerated Benefit Rider and Confined Care Accelerated Benefit Rider Disclosure Forms have been presented to the applicant, if applicable. AGENT'S REMARKS:_____

Charles Turner (AGENT'S PRINTED NAME) 3/14/2022 11:25:33 AM (DATE) _____ (AGENT'S PRINTED NAME) _____ (DATE)

Agent Charles Turner (e-signed) (SIGNATURE) No: 22690 % _____ Agent _____ (SIGNATURE) No: _____ % _____

PREAUTHORIZATION CHECK PLAN - AUTHORIZATION TO HONOR CHARGE DRAWN

Insured DAVID SALAIZ Account Holder David Salaiz

Financial Institution Bank Of America Address El Paso Tx

Transit/ABA Number [redacted] Account Number [redacted] ☒ Checking ☐ Savings Requested Draft Day (1st-28th) 25

ATTACH VOIDED CHECK OR DEPOSIT SLIP

As a convenience to me, I hereby request and authorize you to pay and charge to my account amounts drawn on my account, whether by electronic or paper means, by and payable to the order of Pioneer American Insurance Company, for the purpose of paying premiums on life insurance policy, provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights with respect to each such charge shall be the same as if it were signed personally by me. This authorization is to remain in effect until revoked by me in writing and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

DAVID SALAIZ (Voice Signature on File) (SIGNATURE AS ON FINANCIAL INSTITUTION RECORDS) — 3/14/2022 11:25:33 AM (DATE)

Form No. ICC15-PA9466

2200094771620

EXHIBIT F

American-Amicable Life Insurance Company of Texas
P.O. Box 2549
Waco, Texas 76702-2549
1-800-736-7311
www.AmericanAmicable.com

SPECIAL LATE PAYMENT OFFER
GRACE PERIOD HAS EXPIRED

E-mail questions to:
premiumaccounting@AmericanAmicable.com

BRANDON CALLIER
6336 FRANKLIN TRAIL DR
EL PASO TX 79912

You may go online to make a one-time credit card or bank account payment by logging in to your policy at www.americanamicable.com. If mailing a check, please write your policy number on your check and return the bottom portion of this notice.

Policy Number	Payment Due	No. of Months	Payment Type	Amount Due	Offer Expires
0103531760	03-10-22	1	LIFE PREMIUM	60.65	05-09-22
	04-10-22	1	LIFE PREMIUM	60.65	
			PAY THIS AMOUNT	121.30	

Your coverage shall terminate or lapse except as to the right to any cash surrender value or non forfeiture benefit. We will reinstate your policy upon receipt of the amount due if full payment is received at our office on or before the date shown under OFFER EXPIRES and if it is received during the lifetime of each person insured under this policy and prior to the disability of any person covered for waiver of premium disability.

If you have already paid the amount due, please disregard this notice.

PLEASE RETAIN TOP PORTION FOR YOUR RECORDS.

PLEASE RETURN THIS NOTICE WITH YOUR PAYMENT.

American-Amicable Life Insurance Company of Texas
P.O. Box 2549
Waco, Texas 76702-2549
1-800-736-7311
www.AmericanAmicable.com

SPECIAL LATE PAYMENT OFFER
GRACE PERIOD HAS EXPIRED

Policy Number	Due Date	No. of Months
0103531760	03-10-22	2

BRANDON CALLIER
6336 FRANKLIN TRAIL DR
EL PASO TX 79912

LIFE PREMIUM	121.30
PAY THIS AMOUNT	121.30

031022G11041047400012130

Form 588AA1